## Dr. Bruce Gipe

Dr. Gipe was born in Corona, CA in 1953. He grew up in Orange County and in Phoenix and Prescott, Arizona where he graduated from Prescott High School. He attended Point Loma Nazarene University in San Diego, CA and graduated summa cum laude with a BS in Chemistry in 1976. He attended medical school at Loma Linda University School of Medicine where he graduated with his M.D. in 1979. From 1979 to 1982 he did his internship and residency in Family Medicine at San Bernardino County Medical Center (now Arrowhead Regional Medical Center). From 1982 to 1985 he completed further training in Internal Medicine at Loma Linda. From 1985 to 1987 he practiced emergency medicine in the Palm Springs area, and from 1987 to 1990 he completed a fellowship in Pulmonary and Critical Care Medicine at the UCLA Medical Center. From 1990 to 1992 he served on the full time faculty at UCLA. Dr. Gipe maintains board certification in Internal Medicine, Emergency Medicine, Pulmonary Medicine, and Critical Care Medicine. Since leaving UCLA he has been in private practice and is the founder and Medical Director of Primary Critical Care Medical Group, a hospitalist and intensivist physician practice management company. PCCMG is based in North Hollywood, CA, and Dr. Gipe lives with his wife and two sons in Studio City.

# Update on Hospitalist Medicine in California and the United States

Bruce Gipe, MD, Medical Director
Primary Critical Care Medical Group
North Hollywood, CA

# Physician Comp Will Decrease

- Healthcare is 17% of GDP
- SGR is still out there and could cut 20% from FFS payment
- Payment/procedure = “solve for income”
- Tax rates are going up and you are “rich”
- Taking advantage of pre tax advantaged options requires foresight and discipline if you don’t want to work until you are 70


NO PARKING
2:00am to 6:00am
DEATH FROM DROWNING HAPPENS
ONCE IN A LIFETIME
UNDERTOW & SURF CAN MAKE RETURN TO SHORE IMPOSSIBLE
PELIGRO
MOLUSCOS
ALMEJAS
WARNING
MUSSELS
CLAMS
Please do not
Feed the
Wildlife
as it is
Hazardous
to their health
and yours.
BEACH INFORMATION
MORRO ROCK ACCESS
Dogs Must be on Leash
Camping Prohibited
No Vehicles on Beach
No Smoking on Beach
Campfires in Designated
Containers Only
WARNING
Enter water at your own risk.

# Who to Work For?

- NYT, 3.25.10, More Doctors Giving Up Private Practices
- In 2005 2/3 of practices were physician owned
- In 2008 it was down to < 50%

# Why the Decline?

- Concerns re medical errors
- Changes in payments, e.g. push to increase PCP comp has caused specialists to consider selling
- E.H.R. cost
- Call schedules

# How to compete

- Be available
- Be nice
- Demonstrate competency
- There are about 85,000 licensed physicians in CA and about 24,000 in Los Angeles County!

Phyllis Maguire

# A national hospitalist company finds a warm welcome on Wall Street

**IPC-THE HOSPITALIST COMPANY,** which is known for its strong embrace of the private practice hospitalist model, is now also known by a new symbol: IPCM.

That's how the company is being listed on the NASDAQ exchange. Earlier this year, IPC, which is based in North Hollywood, Calif., became the first national hospitalist company to go public, raising nearly $94 million before the fees and expenses related to the initial public offering were deducted.

According to chief executive officer Adam Singer, MD, that effort was the culmination of what has been the company's goal all along: to become a publicly traded company.

Dr. Singer talked to Today's Hospitalist about IPC's new business model.

**Why did IPC decide to go public?**

You go public for two classic reasons: to raise money and provide liquidity to your shareholders.

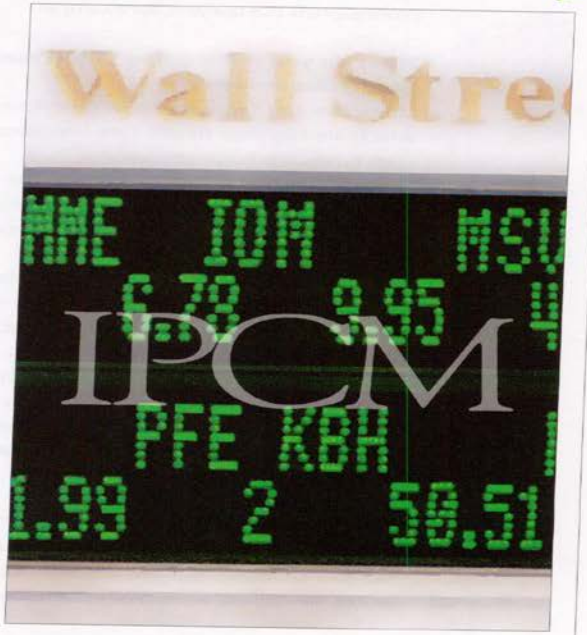
We had previously raised more than $40 million in venture capital—with the last raising of capital in 2002—and we have been profitable since 2002. When you raise venture capital, you're really setting the stage for going public, and we had planned to go public since our inception in 1997.

But there is a third reason: We wanted to be able to stand up and finally define for the public what is a hospitalist and to set the bar for how a hospitalist is going to be measured in the public domain.

**What was the reaction from the investment community?**

It reminded me very much of the early 1990s, when we had to educate other health care providers about hospital medicine. Within the financial community, there was just a complete blank in terms of knowing what hospital medicine was. Was it hospice? Or hospitality? They had no idea.

We found that lay investors, mutual fund managers, money managers, people in the Wall Street world are relatively young. So we are not talking to people who are big consumers of health care.




REGIONAL
MEDICAL CENTER
PCCMG
HOSPITALISTS

# Beginnings ...

- 1980 ... license
- EM moonlighting/residency X 2
- Full time EM in Palm Springs, 1985-87
- Pulm/CCM fellowship at UCLA, 1987-90
- Faculty UCLA, 1990-92
- Private practice, 1992-present

# Vision ...

- To create a medical group that provided hospitals with intensivists to staff their intensive care units

- Reasons why this couldn't work in 1992

# Contracts

- 1992 LTAC, California
- 1994 ED, Huntington Beach
- 1995 ED + hospitalist, Exeter
- 1995 IM Clinic, Huntington Beach
- 1996 Primary Care Clinic, Farmersville
- 1996 ED, Coalinga

# Contracts

- 1997 Hospitalist, Bakersfield
- 1997 EM, Dinuba
- 1998 Kaiser
- 1998 Hospitalist, LTAC
- 1999 Hospitalist, Marysville
- 1998 EM, King City
- 2000 EM, Fallbrook

# Contracts …

- 2000 Hospitalist Oxnard
- 2002 Hospitalist ARMC
- 2002 Hospitalist Turlock
- 2004 Hospitalist Kona
- 2005 Hospitalist Hilo

# Contracts

- 2006 Hospitalist MLK
- 2007 Hospitalist/Intensivist Rancho
- 2008 Hospitalist HUMC
- 2008 Hospitalist DRMC
- 2009 Hospitalist USC
- 2010 ED Hospitalist HUMC
- 2011 Neurohospitalist DRMC

# Current

- 130,000 encounters/year
- Contracts to cover > 100 facilities
- Mix of traditional and non-traditional hospitalist contracts
- Academic and non-academic
- 1 EM
- 2 intensivist

# STATE OF THE ART

- About 20,000 currently practicing hospitalists
- Estimated need: 30,000 (= same # of cardiologists in U.S.)
- 29% of hospitals have hospitalists
- 55% with >200 beds have a program

# Demographics: 2011 SHM Survey

- 50% single specialty
- 6% founded in 2010, 21% prior to 2000
- 88% internists, 5% FM, 5% peds, 1.3% PA or NP
- 65% male, 35% female

# Group Size

- 26% = 16 or more
- 26% = 10-15
- 38% = 4-9
- 11% = 3 or less

# Finances

- Median support = $131,564/FTE; $119,064 in West
- $220,619 ... higher for local hospitalist only groups vs. employment by multi-state group or management company
- South = $247K, East = $212K

# Why do you need support?

- A robust daytime program depends on an equally robust night and weekend program—the night coverage must be there but won't generate as much revenue
- Unfunded care obligations
- Maintain the proper ratio to avoid burnout and achieve results

# RESIDENCY PROGRAMS (JAMA 9/1/04—Vol. 292, # 9)

- 6,345 IM graduates in ’02-’03 (about 5% plan to stay in GIM)
- 86 CCM graduates
- 359 Pulm/CCM graduates
- 3,251 FM graduates
- 21,351 IM residents on duty—8,591 IMG residents, 1,183 AOA

# HOW TO BUILD ONE

- Why are you doing it?
- Enlist support of key stakeholders.
- Define the size of the service.
- Define the payor mix.
- Estimate revenue from FFS billing.
- Select a staffing model and estimate expenses.

# Advantages of Hospitalist Programs

- Finite group of contracted physicians allows potential for better results with quality initiatives: core measures, antibiotic stewardship, HCAHPS, sepsis, readmission
- Greater efficiency → reduced LOS
- Solves call panel coverage problem for unassigned
- Provides local PCPs with coverage options
- Communication around handoffs and sign outs
- In house night coverage for admissions and rapid response
- Collaboration with intensivists

# Program Components

- Clinicians who are committed to achieving excellent results and who understand the value of teamwork and are able to empathize with patients and families in their time of need,
- A local Medical Director who actively participates in patient care while providing the clinical and administrative leadership with a point of contact for working through complaints and challenges,
- Infrastructure to support operations: recruitment, credentialing, scheduling, Call Center, billing, reporting, performance improvement, and risk management,

# Components of Hospitalist Program … 2

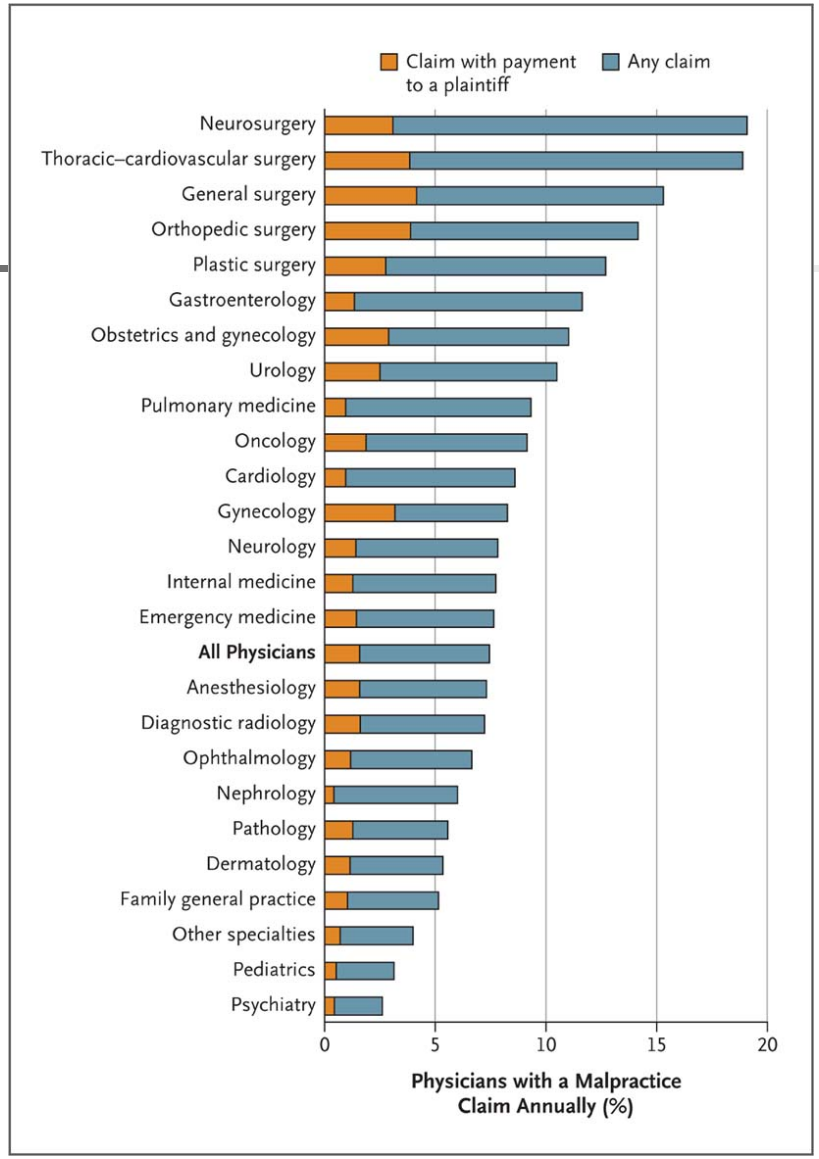
- Weekly hospitalist team meetings to focus group on key issues,
- Coaching and mentoring for hospitalists in order to facilitate orientation and collaboration with facility and medical staff,
- Active participation in medical staff committees by core hospitalists,
- Tracking and reporting on key metrics in order to achieve program goals: ALOS, timing of discharge order writing, satisfaction/HCAHPS, core measures, sepsis bundle, antibiotic stewardship, etc.

# Credentialing, Professional

- Cognitive vs. procedural emphasis
- Society of Hospitalist Medicine: www.hospitalmedicine.org

# Malpractice

- Communication: hospitalists don't have a prior relationship
- Medication management
- Who's in charge?
- Handoff communication


Claim with payment to a plaintiff
Any claim
Neurosurgery
Thoracic–cardiovascular surgery
General surgery
Orthopedic surgery
Plastic surgery
Gastroenterology
Obstetrics and gynecology
Urology
Pulmonary medicine
Oncology
Cardiology
Gynecology
Neurology
Internal medicine
Emergency medicine
All Physicians
Anesthesiology
Diagnostic radiology
Ophthalmology
Nephrology
Pathology
Dermatology
Family general practice
Other specialties
Pediatrics
Psychiatry
0
5
10
15
20
Physicians with a Malpractice Claim Annually (%)

- “Concern for man and his fate must always form the chief interest of all technical endeavors ... never forget this in the midst of your diagrams and equations.”

- Albert Einstein, 1885